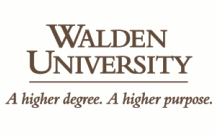

2015

Care Transition Gaps: Risk Identification and Intervention

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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2015

Abstract

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Submitted in Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2015

Abstract

Hospital readmissions related to chronic heart failure (CHF) are costly, widespread, and often avoidable. Patient education that includes diagnosis, causes, medications, diet, exercise, and exacerbation warning signs has been shown to reduce the number of CHF readmissions. The purpose of this study was to use risk stratification to identify CHF patients at high risk for 30-day readmission. Once a high-risk CHF patient was identified, nursing interventions would be triggered to reduce readmissions and close the gaps in the continuum of care following acute care admission. Transitions of care theory was used as the framework for this project. The methodology had a quality improvement focus. The patient population consisted of high-risk CHF patients (n = 25) with NYHA classification of II-IV using the risk identification tool. Patients were identified using the tool, were followed for 30 days, and received nursing interventions to reduce the possibility of readmission. Only one of the identified patients was readmitted within 30 days for a diagnosis unrelated to CHF, resulting in no readmissions within this sub group. This study suggests that risk stratification can identify and direct resources to CHF patients, decreasing their likelihood for readmission. Nurse leaders can use standardized tools such as the risk identification tool, thereby reducing readmissions along with associated costs for readmissions.

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Acknowledgements

A special thank you to my project committee as I appreciate your time and expertise on my behalf. I would like to thank the many friends, family and professional colleagues who have supported and given me great strength along this journey. Specifically I would like to recognize my nursing leadership mentors: Kim Collinelli RN, Nancy Tsuyuki RN, Mary Lou Cohen RN, Peggy Crabtree RN, Valarie Fleming RN, and Mary Kingston RN. The greatest appreciation goes to Nurse Erin, my wife and my closest friend.

Table of Contents

Section 1: Care Transition Gaps: Risk Identification and Intervention

Overview

Hospital readmissions are costly, widespread, and often can be avoided. Researchers have estimated that 20% of Medicare patients who are discharged from acute care hospitals are readmitted within 30 days of discharge, and 34% within 90 days (Jencks, Williams & Coleman, 2009). Researchers have further estimated that more than 1 in 3 adults live with cardiovascular disease (Healthy People 2020, 2013). This is significant as the 30-day readmission rate for Chronic Heart Failure (CHF) nationally is 25% and in some institutions, greater (Dharmarajan et al., 2013). The economics of health care, combined with rising costs, are making operational changes necessary for financial stability of organizations.

Hospitals can focus interventions and improvements for avoidable readmissions. Data regarding 30-day readmissions is collected and analyzed in acute care facilities as reimbursement and penalties are incurred for avoidable readmissions. Snyderman, Salzman, Mills, Hersh, and Parks (2014) explained that patients who are 65 years or older consistently have the highest rate of hospital readmissions. Thus, nursing professionals acknowledge the importance of assessing the interaction between psychosocial factors in CHF readmissions. Nurses continue to evaluate the relationship between psychosocial and emotional variables because quality of life and life expectancy can be improved for those with heart failure through early diagnosis and consistent treatment.

Congestive heart failure is a chronic, progressive, degenerative disease of a weakened heart muscle that is also often accompanied by other disease pathways.

Cardiac health issues such as myocardial infarction, heart murmurs, hypertension, diabetes, cardiomegaly, sedentary lifestyle, and poor diet increase the risk of developing CHF. Patient education and understanding is therefore imperative and should include diagnosis, causes, medications, diet, exercise, and exacerbation warning signs in order to reduce the impact the disease has on a patient's life.

Advance Practice Nurses (APNs) can also help by developing and translating strategies to lower the rate of avoidable readmissions. Hospitals are faced with closure of programs, such as cardiac rehabilitation in order to lower costs. However, this is a critical program aimed at educating and enabling patients to heal while sustaining their health. The shift in emphasis from control of illness to maintenance of wellness means that other solutions must be provided if hospitals close valuable programs such as cardiac rehabilitation.

Collecting data on certain high-risk patients in populations such as CHF, is a proactive step in determining readmission reasons and targeting reduction interventions. Researchers have estimated that 5.8 million adults are living with heart failure in the United States, and they expect this number to grow by 25% by 2030 (Dunlay, Pereira, & Kushwaha, 2014). An effective, multidisciplinary, and accessible program could address lifestyle and dietary changes, exercise, and medication management. Additionally, this type of program could impact costly hospital readmissions (Hunt et al, 2009) and quality of life for patients, families, and the community at large.

The majority of CHF patients have comorbidities that exacerbate their underlying disease. Congestive heart failure and associated comorbidities account for more than

30% of hospital admissions. Nationally, 1 in 4 heart failure patients will be readmitted to the hospital following discharge, or seek emergency services within one year of discharge (Dunlay, Pereira, & Kushwaha, 2014). Multiple diseases combined with comorbidities have led the Heart Failure Society of America to recommend assessment of CHF patient's psychological and cognitive status to determine readiness to participate in their care.

The main focus of this research is to use the risk stratification tool (Appendix A) and associated interventions at Providence Little Company of Mary Medical Center Torrance (PLCMMCT) for patients admitted with CHF. The tool would be used by Registered Nurses (RNs) to recognize patient risk for readmission and institute specific interventions that would decrease readmissions within the first 30 days after discharge. Currently, PLCMMCT experiences a 21% annual readmission rate for heart failure patients.

The outcomes and measurements in CHF are multivariable. A nurse's ability to provide interventions that enable patients to adhere and comply with educational goals is an integral component in reducing 30-day readmissions. Adherence to new diet regimens as evidenced by a diet diary over a 3-month period is one example of a change that can decrease exacerbation of heart failure (Akosah & Carothers, 2004). Additionally, follow-up appointments need to be kept and patients must be able to understand and repeat back what is learned about the disease processes such as cause, treatment, and when to seek assistance. Cessation of smoking, minimal intake of alcohol, and maintenance of normal

blood pressure are other goals that should be undertaken to reduce incidence of exacerbation that lead to readmission.

Problem Statement

This project addresses the increased frequency of readmission of adults with exacerbation of existing CHF at PLCMMCT, as evidenced by the increased number of patients readmitted with CHF or a CHF-related diagnosis within 30 days of discharge. Adherence to medication and lifestyle changes is critical to successfully managing CHF, reducing hospital admissions, and increasing survival rates. The Centre for Reviews and Dissemination (2012) has shown that patients are more likely to adhere to a once-a-day medication regimen. This is an opportunity to create chronic disease programs that take into consideration the individual needs of the patient linking the various aspects of their care.

A continuum of care facilitates patient flow across all potential care areas. The gap addressed is between acute hospital care and wellness. Gaps in the continuum of care create greater situational, psychological, cognitive, and physical issues that have a negative effect on the self-management abilities of patients. This only intensifies issues in the CHF patient population related to medication regimens and follow-up with providers, thereby increasing exacerbation leading to increased readmission to the acute setting (Stauffer et al., 2011). The opportunity exists to integrate a risk stratification tool and nursing interventions that ensure continuity during transitions from the inpatient setting. Understanding the risk of patients with CHF patients better enables resources to

be more aligned enabling specific nursing interventions and reducing readmissions (Snyderman et al, 2014).

Purpose Statement and Project Objectives

Nearly every health system claims to offer a continuum of care on their individual website. The continuum of care concept involves an integrated system of care that guides and tracks a patient over time through a comprehensive array of health services spanning all levels of care. Health care systems often fail to provide high quality care across that continuum. Readmissions reveal a lack of coordination between the many services offered. For example, a CHF patient may benefit by a referral to home care, but if that referral is never made the patient may lack the support they need at home. A patient traveling through the most sophisticated health care system may cycle through the journey over and over again.

The purpose of this project is to use risk stratification to trigger nursing interventions based on various risk levels that will be tested at PLCMMCT. The tool will be used to identify CHF patients who are high risk for readmission within 30 days of discharge from acute care. Specific nursing interventions, identified by the tool, and follow up on discharged will be integrated in order to achieve reduction in readmissions, working to close the gaps that exist in the continuum of care following an acute care admission.

Researchers have predicted that the elderly population 65 and greater will almost double from the year 2005 to 2030 (Retooling for an Aging America, Institute of Medicine [IOM], 2008). Focusing interventions on increasing self-care in this population

will fill gaps in the continuum of care. Risk stratification has proved useful in identifying patients in need of further intervention (Kansagara, et al, 2011). The reasons for readmission can be further understood by examining the CHF patients' experiences related to self-care and transitions in and out of the hospital.

Significance to Practice

Nurses have a responsibility to ensure there is an emphasis placed on quality in the healthcare environment. According to Hood (2006) a professional nurse must change adapt to multiple career stages. Nurses have a vital role in the revamping and transforming health care in the United States. Increasingly, the outcome data are of the utmost importance, but the profession has struggled with data collection. The Affordable Care Act has placed greater emphasis on data collection and submission. The electronic atmosphere has improved tracking of quality initiatives, but the legitimacy of the information may be challenged; data can be collected incorrectly thus leading to inaccurate conclusions. Electronic data can be helpful in understanding issues related to all readmissions.

Unplanned CHF readmissions represent an increasingly large problem nationally in healthcare (Snyderman et al, 2014). Thirty-day readmission rates are a crucial measure for hospitals due to penalties imposed by the Centers of Medicare and Medicaid Services. Nurses play a unique role in bringing changes in transitions of care directly to the patient (Lewis, 2012). Beyond providing the acute care needed once a patient is admitted, the nurse also provides the connection to the resources that enable a patient to remain stable following discharge (Case, Haynes, Holaday, & Parker, 2010).

The RN can provide follow-up for the CHF patient built on the four pillars of the Coleman model of transitions. The areas of emphasis, or pillars, are: (a) medication self-management, (b) patient centered medical record, (c) follow-up with physicians, and (d) patient acknowledgment of red flags or signs of exacerbation. The care transitions model has been successfully used to educate CHF patients at risk of readmission (Coleman, Parry, Chalmers, & Min, 2006). Improved 30-day readmission rates have been achieved with better management of chronic illness combined with RN follow-up through home visits and or telephone calls. The RN reviews medications to be taken, educates patients about how to schedule follow-up visits, and helps patients recognize warning signs that should prompt them to call or immediately visit a care provider, breaking the cycle of acute exacerbation.

Reductions in hospital readmissions have been achieved with interventions focused on the transitions and support of patients post discharge. Coleman et al. (2006) reduced readmissions from 20% to 12.8 % in a cohort, randomized controlled study on transitional care. The connection and communication with nurses in the hospital and the days following discharge better enables patients to transition to home care, reducing incidence of 30-day readmission (Snyderman et al, 2014). This project specifically uses a risk stratification tool that will identify high-risk patients for readmission. Once a patient is identified as high-risk, nursing interventions addressing a personalized transition of care plan including specific education needs at discharge including medications, physician appointments, and signs of exacerbation will be implemented.

Project Question

Population, intervention, control, and outcome (PICO) question: Among hospitalized patients diagnosed with exacerbated CHF, does risk stratification and creation of a personalized transition of care plan by the RN with targeted interventions, as compared to standard care (no risk stratification or targeted interventions) result in fewer readmissions?

Evidence-Based Significance of the Project

Greene (2012) explained that hospitals are struggling to find a solution for a multifaceted problem centered on fears of penalties for high avoidable readmission rates. There needs to be assurance that no gaps exist as patient's transition through the continuum of care. Readmissions occur due to a variety of causes (Kelly, 2011). Because older patients often suffer from multiple health issues and chronic illnesses transitions need to be seamless. Chronic heart failure does not always follow a logical progression, as evidenced by varied comorbidities. Also, financial motivators such as reduced reimbursements and increased expenses are strong drivers for facilities to find a solution. Administrators must consider that reductions in length of stay, combined with fewer homes care visits, can result in increased readmissions, as patients are not getting the needed education to self-manage their disease.

Coleman's transition of care framework (Coleman, Parry, Chalmers, & Min, 2006) offered evidenced-based practice (EBP) direction for research on the transitions of care. Kelly (2011) discussed the importance of interventions to reduce readmission rates and reflects the current issues around self-care in the transition of care. There is

opportunity to change care for older adults across the continuum by providing patient-centered care (Coleman et al., 2002). Risk assessment has limitations, but is useful in directing resources and interventions where they are needed.

The transition of care framework touches on nursing caring theories, particularly self-care and self-care management (Orem, 2001). Improved outcomes can be obtained for those suffering from chronic illness by using Coleman's framework as a basis to undertake research and develop interventions. Recent studies are focusing on actual experiences of the patients, placing the patient at the center of care, rather than the caregivers (Yen et al, 2011).

The EBP discussed here and in the literature that have been shown to bridge the gaps in transition. The literature review conducted describes transitional care interventions as those interventions that are designed to reduce readmissions among populations who are transitioning from care setting to another (Feltner et al, 2014). Intensity of interventions can be tailored to patients through the use of risk stratification tools (Snyderman et al, 2014). While risk stratification modeling is a work in progress, efficiencies must be obtained to focus resources where they are needed most. However, some models have proved useful in certain settings and are worth further evaluation (Kansagara, et al, 2011). Feltner et al. (2014) analyzed 47 trials and determined that programs to reduce CHF readmits must maintain a strategy that fully supports patient's pre and post-discharge. Additionally, Feltner et al. found that many of these programs reported cost savings.

Applying this research to the population admitted for acute exacerbation of CHF will enable PLCMMCT to identify those patients that are high risk for readmission. Once these patients are identified through risk scoring, resources can be applied where they are most needed. Given that patients are extremely vulnerable for readmission during transitions from hospital to home, the proposed interventions focus on this period. A multidisciplinary team focusing on early and accurate disease information will positively affect continuity of care, as well as patient safety and satisfaction while providing efficient use of resources.

Implications for Social Change

Diseases such as CHF significantly impair the patient's ability to function. Social responsibility is advocacy for the greater communities, and nurses have the expertise to advance human caring as professional patient advocates (Tyer-Viola et al, 2009). Properly preparing patients for self-care through education can reduce hospital readmissions by preparing patients for the transition from the acute care setting to home. The readmission of chronically ill patients continues to be a health care problem and occurs through a variety of causes (Kelly, 2011). Elderly patients often suffer from a combination of health issues and chronic diseases impairing their ability to function normally and reducing their quality of life. The research reviewed reveals the practice problem is affecting health care locally and nationally. The transition of care framework offers possible direction for interventions that can improve outcomes, ultimately reducing readmissions. The research shows a gap in the continuum of care. Lack of adherence to medication regimens or follow-up with providers are areas that increase exacerbation of

heart failure, thereby increasing readmission to hospitals (Stauffer, et al, 2011). This work represents a deliberate process, integrating evidence-based nursing interventions in bringing about social change for a vulnerable population.

The DNP researcher can keep the review of literature pertinent to the desired subject by focusing on the practice problem, as well as the patient population (Terry, 2012). In the context of the transitions of care model, there is an overlap with both patient centered care (PCC) and self-care. The Institute of Medicine has brought prominence to PCC making patient centered outcomes the theme of recent research (Epstein & Street, 2011). Self-care can be approached and described as one of the essential components in chronic disease management. Self-care is influenced by many factors. Maintaining health is dynamic and these factors can help articulate the subjective and dynamic nature of health and promote practices that enable management of chronic diseases (Riegel, Jaarsma & Stromberg, 2012). A defining feature of EBP is linking the current research findings with patient values, conditions and circumstances (Zaccagnini & White, 2011). Riegel, Jaarsma, and Stromberg (2012) evaluated readmissions for chronic illness from a self-care perspective. Implementing nursing interventions for high-risk patients with CHF specific to helping them better manage their chronic illness can, therefore, reduce the readmission rate.

Summary

Hospitals continue to experience challenges around readmissions centered on reimbursement penalties. Medicare estimated that in 2004 the cost of unplanned re-hospitalization was $17.4 billion, causing the Centers for Medicare and Medicaid

Services to impose penalties for readmissions within 30-days (Snyderman et al, 2014). Linking current research findings with a patient's conditions, values, and circumstances is a defining feature of EBP (Zaccagnini & White, 2011). There is clear opportunity for nurse leaders to improve outcomes through EBP interventions around readmission within my community. By identifying patients at risk for readmission and creating an interdisciplinary plan of care that covers both short term and long-term interventions, the patient will be better able to manage their disease and maintain their health without hospitalization.

Section 2: Review of Scholarly Evidence

Collecting and analyzing etiology and intervention data to determine the cause of readmissions can help achieve reductions in readmissions. Most research has focused efforts on 30-day readmissions; however, the literature shows that interventions are not working beyond the 30-days (Gheorghiade, Vaduganathan, Fonarow, & Bonow, 2013). Patients need health care professionals to focus on more reliable long-term interventions that can improve their quality of life in the face of chronic illness.

Strategies can be developed to help hospitals lower the rate of avoidable readmissions. Patients being discharged are at low capacity for self-care (Leppin et al, 2014). Hospitals can facilitate this by identifying those patients who are at high risk and implementing interventions to increase patient's ability for self-care. The push for positive patient outcomes combined with current economics in health care makes this an important issue for acute care hospitals to resolve. The literature reflects a focus on the various issues with readmissions. Effective interventions to reduce readmissions are

found in the research and pinpoint the specific components interventions need to produce reductions in readmissions (Leppin et al, 2014). Highly supportive discharge interventions enhance patient capacity to enact burdensome self-care and avoid readmissions.

The purpose of the literature review is to establish the value that previous research can provide on the topic (Terry, 2012), identifying evidence of interventions that can reduce the problem of readmissions among CHF patients. The use of tools in combination with education can enable patients to care for themselves creating a better quality of life and reduce readmissions. If readmissions are reduced nationally, the financial hardship placed on health care may also be reduced. Hospital to Home (H2H) is an example of a program that can assist in sharing best practices and increase knowledge around these patients (American College of Cardiology, 2013).

General Literature

The focus on interventions around transitions in care is due to consistent increases in readmissions to the acute care setting. The Joint Commission has remained focused on patient handoffs as a national patient safety goal. Hospitals have an imperative to understand the current state and the current research that pertains to gaps in transitions of care before implementing a transitional care intervention or quality improvement project. Evaluating the strength and consistency of the evidence in the literature is key to understanding the strength of current clinical interventions.

An extensive Internet search was performed using nursing Cumulative Index of Nursing and Allied Health Literature (CINAHL), medical (MEDLINE, PUBMED) and

general databases available through the Walden University Library. The searches produced over 500 articles, theoretical papers, dissertations, meta-analyses, reviews, and empirical research studies that provide support for this project. The search of systematic reviews and study articles of transitional care models or interventions was conducted using combinations of the key words nurse practitioner, APN, transitional care, re-hospitalization, readmission, nurse-led, heart failure, and care transitions. The most prevalent level of evidence in these articles is Level C or B using American Association of Colleges of Nursing evidence leveling system (Armola et al, 2009).

As health care moves through changes in economics and clinical care, the patient needs to remain at the center of decisions using EBP to ensure outcomes are consistent with quality and safety. Patients are being discharged sooner with a focus on reducing length of stay (LOS), however, this is not without a cost. Unruh, Trivedi, Grabowski and Mor (2013) explained that a reduction in LOS by one day was associated with readmission in patients with complications. While nursing has increased the amount of information they are providing patients to take home, the face-to-face time and direct education with return demonstration has declined. There are many gaps in the education being provided to patients limiting their ability to recognize the signs and symptoms related to the disease (Slater, Phillips, & Woodard, 2008).

Prior to discharge, patients need crucial information related to their disease allowing their transition to be bridged with valuable strategies to maintaining health. Post discharge calls help patients understand their treatment and medications limiting the chances of compromised health (Rush, 2012). The overall patient experience is also

enhanced as the gaps in transition are filled, guiding patients through the pitfalls causing readmission. Rush (2012) reported that making discharge calls is not without issue in large systems but there are many benefits that can be realized. Instituting discharge calls provide nurses an opportunity to positively impact the quality and safety of patients treated. Discharge calls promote a patient and family centered approach to care by ensuring they have their needs met and questions answered as measured through increased patient satisfaction. Patients often have difficulty understanding written instructions as well as recalling what was told them by the health care providers (Engel et al., 2009). Establishing a relationship with the patient, determining their unique needs, integrating those needs into the discharge teaching, and following up with the patient after discharge could facilitate better understanding and compliance. This, in turn, would help the patient achieve that level of being able to self-manage their care.

In a summary of lessons learned, Rush (2013) acknowledged the importance of education to staff members. A standard process needs to be developed taught and audited during the early phases of the practice change to ensure success. Staff must become competent in any new practice change to enable their success or the results can be negative. Inconsistency often results in poor satisfaction for patients and a poor coalition within the team. A team of influential leaders must be formed to provide the foundation needed to realize success in changes that are to be implemented. Meeting these conditions nurses experience many examples of saves with patients that would likely be readmitted do to exacerbation without intervention (Rush, 2012). Questions asked of patients require teach-back as a technique to ensure that patients understand the

instructions. When patients explain what they have been taught this reinforces the education they have received prior to discharge, at the time of call follow up, and with physician appointments.

The identification of transitional care is defined as services and environments designed to ensure health care continuity complimenting primary care and avoid preventable poor outcomes among populations at risk, as they move from one level of care to another (Naylor, Aiken, Kurtzman, Olds and Hirschman, 2011). The article focused on studies that included interventions based on this definition of transitional care targeting adults with a chronic disease or complex health issue.

Beyond the efforts by TJC-instituted national patient safety goals, the Affordable Care Act of 2010 has introduced a variety of programs and services around transitions of care to improve quality and reduce costs associated with readmissions. The literature demonstrates that programs designed for hospitalized patients with complex chronic conditions can help with transitions in a safe and timely manner from one level of care to another. In both this review, and the reviews conducted by Naylor et al. (2011), many interventions demonstrated positive effects on measures centered on health reform and readmissions.

In the literature reviewed, successful interventions shared commonalities such as a nurse-led program and included home visits or follow up calls following discharge. Neff, Madigan, and Narsavage (2003) evaluated an intensive home follow-up program for patients that did not include any inpatient component. Another article by Jencks, Williams, and Coleman (2009) evaluated a comprehensive discharge-planning

intervention that integrated a post discharge phone call from a pharmacist for medication reconciliation. Interventions in these studies and in Coleman et al. (2006) led to reductions in readmissions producing positive outcomes beyond 30 days after discharge. It should be noted that successful follow up is reported when trained nurses are performing education that guides patients and helps them to gain confidence in managing their illness (Slater, Phillips & Woodard, 2008). Hospital readmissions are increased when patients are not properly educated or prepared for the transition from the acute care setting. When patients are enabled and empowered to care for themselves, the best outcomes, reduced readmissions, and cost control can be achieved.

The literature reinforces this lack of education is affecting health care nationally and the transition of care framework offers some insight into interventions to improve outcomes reducing readmissions in this population. The older population will almost double in the next 15 years based on the IOM report, *Retooling for an Aging America: Building the Health Care Workforce* (2008). The gap that exists in the continuum of care only exacerbates issues related to medication regimens and follow-up with providers leading to exacerbation of heart failure and increasing readmission to the acute setting (Stauffer et al, 2011).

As health care organizations struggle with increasing costs and reduced reimbursements, decreasing readmissions offers the potential of increased quality, better outcomes, and reduced costs. Timing is a key factor that can exponentially assist in bringing a proposed change forward for consideration. Slater, Phillips and Woodard (2008) reported the cost of admission for CHF patients decreased from $11,993 to $6,553

per admission when the patient received a follow-up call after discharge. These costs are primarily associated with a reduction in the length of stay following targeted education by trained nurses. The success in a reduction of readmissions is also associated with specialty, or focused, units due to the level of expertise of nurses providing education (Jensen, 2011).

Enabling patients to care for themselves through use of tools and education create a better quality of life. If done correctly, this self-care also reduces the financial hardship on healthcare. There are many institutions that could share best practice. Programs such as Hospital to Home (H2H) are helping to increase knowledge of these practices (American College of Cardiology, 2013).

Conceptual Models and Theoretical Frameworks

Nursing theories are abstract ideas directing nursing research and education as well as the practice of nursing. The implementation of practice changes and specialized ideas using nursing theory should lead toward improved patient safety and increase positive patient outcomes. Practice changes using nursing theory must be evaluated for appropriateness in the patient population where it will be used. This should occur prior to implementation of the theory chosen. When putting a theory in practice, one needs to consider the ways in which the approach will affect the nursing unit by assessing the potential for observing and recording factors that are relevant to the theory's application (Chinn, 2008).

Middle range theories were evaluated using the Fawcett and Garity (2009) model for evaluating nursing theory. In an effort to evaluate the theory , the concepts and

propositions put forth in the conceptual model were examined. Four criteria—*significance, internal consistency, parsimony, and testability*—were used to evaluate the middle-range theories.

Changes in health and illness of individuals are looked at from various perspectives to evaluate a potential process of transition. The vulnerability of clients during transitions is viewed to place them at higher risk to have further adverse health events. The theory seeks to identify these risks through gaining an understanding of the transition process. Feltner et al. (2014) suggested the uncoordinated care leads to poor outcomes, based on the concept of transitions as a potential framework to create patient centered interventions. In this article, the emerging middle-range theory of transitions is considered in the light of the types and patterns of transitions, properties of transition experiences, facilitating and inhibiting conditions, process indicators, outcome indicators, and nursing therapeutics (Meleis et al., 2010).

There is a varying degree of vulnerability in patients who are experiencing a change in health status that applies in many settings of care. Understanding how individual patients are affected by the transition between levels of care can help practitioners identify and tailor interventions. The concept of transition is not new to nursing and has been analyzed as reflected in the articles reviewed by Meleis et al., (2010). The research explored offers a direction to evaluate the transition framework in a unique way through specific aspects identified within transitions in health. The transition theory offers a socially important unique framework from which to work on practice problems concerning vulnerable populations.

Riegel et al. (2012) approached chronic illnesses, and the readmission problems related to these illnesses from a self-care perspective. The authors described their theory from the viewpoint of the patient's capabilities with regard to self-management skills related to their disease. Ranges of concepts are evaluated including self-care maintenance, self-care monitoring, and self-care management specifically related to chronic disease management along with patient centered outcomes. Self-care is described and approached as an essential component in the management of chronic illnesses. Factors that influence self-care are used to help articulate the subjective and dynamic nature of maintaining health while promoting practices which enable management of chronic disease (Riegel et al., 2012).

The first middle range theory evaluated is still emerging and remains somewhat abstract or broad in its nature. Factors influencing readmission of patients with chronic illness from both the self-care and transitions middle range theories are considered in each article: experience, skill, motivation, culture, confidence, habits, function, cognition, support from others, and access to care are described. Either theory could easily be applied to the practice problem as outlined. In many aspects the self-care theory covers much of what is being considered in the transitions theory.

The selection of Jean Watson's theory of human caring is a practice theory that can be used by nurses in academia or in the practice setting to assist in providing improved patient care (Parker, 2006). Constant changes in healthcare delivery systems around the world have led to intensified working conditions for nurses. The need to provide nurses with ways to improve their care delivery while caring for the mind, body

and spirit of their patients is essential. With this in mind, Watson's theory is a choice to assist in decreasing the likelihood that the simple concept of caring is not discarded for the tasks being performed. Caring is essential to humanistic values and must be practiced daily with our patients (Cara, 2003). Nurse leaders must focus on these elements ensuring that nurses do not delegate the important work to others who are unable to assess patients appropriately.

According to Watson (1999), the major elements of her theory are (a) the carative factors, (b) the transpersonal caring relationship, (c) the caring occasion/caring moment. The preceding description of the basis of Watson's theory opens the gates for further exploration into this model of nursing theory and how it can be implemented effectively. Watson is not alone and shares similarities with Patricia Benner and Judith Wrubel, being grounded in the essence of nursing in caring (Chinn, 2008). Watson understands, as with Benner (1984) and Wrubel (1989), the essence of caring is found in the actions, thoughts, values and priorities of the practicing nurse.

Jean Watson's aim is to increase the level of caring for patient's mind, body and soul that is directed at the general professional nursing population. The challenge for nursing, then, is not to discover what is missing, weakened, or needed in another, but to nurture that person in situation specific, creative ways and to acknowledge, support, and celebrate the caring that is. The need and desire to change practice for our nurses to better serve our patient is at a high level in the current healthcare environment. Requiring nurse leaders and hospital administrators to be reminded that caring is an essential factor

in improving patient's health must be communicated in order to not forget that caring is not a theory for nursing, but an essential skill.

Using Watson's caring theory may be the change nurses need to understand that no matter how well a skill is performed, people do not care how much you know until they know how much you care. The caring theory approach is a fit for the practice problem considered and over all transitions.

Section 3: Methodology

A systematic investigation is performed to establish facts increasing the understanding around fundamental drivers and responses of behavior in order to determine if applied interventions proposed improve or lower readmission rates (Nash, Reifsnyder, Fabius & Pracilio, 2011). In this case, the systematic investigation is to look at whether the proposed risk stratification tool and nursing interventions when applied to CHF patients in the acute care setting, results in a reduction in 30-day readmissions. When quantifying health problems, the measures of effect are important in determining appropriate interventions. Applying the evidence-based tool and specific nursing interventions at PLCMMCT will determine if the interventions are successful in reducing 30-day readmissions for CHF patients. Developing an intervention based on evidenced based practice and determining the impact on patient outcomes is crucial to improving population health.

Project Design and Methods

There are several strategies to guide the implementation of transitional care under the Affordable Care Act, such as encouraging the adoption of the most effective

interventions through such programs as the Community-Based Care Transitions Program and Medicare shared savings and payment bundling experiments.

The environment or setting would be the hospital and patient's home following discharge from an acute heart failure admission in the hospital. Discharge calls would be conducted by both a pharmacist, for medication reconciliation and facilitation of accurate medication administration, and by a CHF Navigator RN for the discharge follow-up. The goal is to determine the effects of a risk stratification of high-risk CHF patients into a transitional care program, focusing on medication reconciliation, function, primary physician follow-up and post discharge follow-up for a group of heart failure patients discharged from the hospital following an acute episode. There are many factors that influence the need for follow-up (Snyderman et al, 2014), disease severity, management complexity, ability of the patient to provide sufficient self-care, and adequacy of social supports. Discharged patients who receive timely outpatient follow-up are less likely to be readmitted (Dunlay, Pereira, & Kushwaha, 2014).

Friis and Sellers (2009) explained that the typical community interventions are aimed at education and behavior change. The proposed transitional approach targeting needed education related to CHF combined with staying connected through a RN transition coach, coordinator or navigator will enable the changes needed. Heart failure remains responsible for high rates of hospitalizations combined with being a significant source of morbidity and mortality. This small project could show what a large-scale population intervention around improving the quality of care provided in transitions could achieve.

Based on retrospective data, two areas of concern at PLCMMCT are clinical processes of patient care and patient experience. Nearly 20% of patients discharged from hospitals experience adverse drug events (Warden et al, 2014), clearly showing an opportunity to reduce readmission by decreasing inaccurate medication reconciliation, decreasing adverse drug reactions, and strengthening transitional communications with patients. Changes in medications during admission further decrease the chances of patient continuing medications at discharge. An average of 28% to 40% of patient home medications are discontinued during hospitalization, and 45% of medications prescribed at discharge were initiated during the hospital stay, making accurate medication instruction vital (Ng et al, 2013).

The baseline data at PLCMMCT shows inaccurate or missing medications on discharge medication lists. A review of discharge medications revealed an 83% defect rate with patient prescriptions. The national average of prescription compliance (accuracy of adhering to the medication regime) or actual obtaining the prescription after discharge is 30% (Warden et al, 2014). PLCMMCT is at 23% for obtaining prescription prior to discharge, demonstrating opportunity for improvement. Warden et al (2014) points out that 60% of adverse medication events after discharge could be prevented with pre-discharge interventions.

Patient satisfaction is another key area that helps practitioners gauge the connection and/or transition from levels of care from one to another. The current Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) score for patient understanding/explanation of medications at PLCMMCT is currently 57.1%.

Clarke & Milner (2013) reported incremental increases in all levels of patient satisfaction based on discharge calls. Patients who receive a follow-up call after discharge are more likely to consider their experience as positive and the authors also noted reductions in readmissions based on discharge follow-up conducted in a standardized manner.

The 30-day readmission rate at PLCMMCT is averaging 26% for CHF. In the first quarter of 2013, the hospital experienced an 8.3% CHF mortality rate based on Health Services Advisory Group reporting. Discharge calls are currently conducted on 23% of all patients discharged from the hospital. The calls are made by various disciplines including Nursing, Pharmacy, and Case Management. There is no standardized script or methodology for following up on this important patient communication.

This project would standardize the identification of CHF patients at high risk for readmission to ultimately institute interventions to close the gaps previously described, providing a connection of care for this population. The CHF patient, upon admission, will be risk stratified by the CHF Navigator. The score will help direct the interventions needed during the admission, upon discharge and follow-up post discharge along with the other nurse assessments. The CHF Nurse Navigator, based on information received from the tool, will educate and begin planned interventions. This includes follow-up, working in conjunction with the physicians, pharmacy tech, staff nurses, and home health nurses in caring out needed interventions to ensure proper transition and reduce likelihood of readmissions.

Population and Sampling

Specifically, the target population would be admitted patients diagnosed with congestive heart failure, with New York Heart Association (NYHA) classification of II-IV. The basic premise of epidemiology supports that disease, like that of heart disease, does not occur randomly (Friis & Sellers, 2009). A convenience sampling of 25 patients available during the time of the project will be used. This project would use a prospective quality intervention using the population of heart failure patients as described above. Those patients identified high risk for readmission would be called within 24 hours post discharge. The sample would include all patients called over 15-day period and allocated to the experimental group to match the baseline data obtained for comparison. The group would be monitored for 46 days to cover the 30-day readmission target.

The follow-up tool would be implemented for all patients of PLCMMCT who are discharged home with a principle diagnosis of heart failure (HF) or a HF-related problem. The long-term program would be developed so patients discharged with other chronic diseases at high risk for re-hospitalization, such as chronic obstructive pulmonary disease (COPD), could be included in the intervention. This would allow for a wider target population, if needed, to ensure sufficient patient participation in the intervention. Focusing on patients with HF and COPD stems from the observation that these two diagnoses are consistently among the top five seen at PLCMMCT. The evidence shows that approximately 20% of patients in the United States who seek acute care for HF or COPD-related problems are readmitted within 30 days of discharge for a preventable

cause. Patients with known cognitive impairment, or without a reliable caregiver, will be excluded, as will patients who are placed on hospice or palliative care.

Intervention

The number of interventions will vary for each patient depending on the completed risk tool. The major areas or risk being assessed are: previous readmission in last 30 days, problem medications, psychiatric complications, principle diagnosis, poly-pharmacy, poor health literacy, patient support, prior hospitalization and palliative care. The interventions will be initiated based on the CHF navigator's assessment of all of these key areas of risk. All high-risk patients will receive universal interventions including: Verification of primary care physician (PCP), follow-up appointment with PCP five days post discharge, home health order and medications filled prior to discharge.

There are gaps in the adult chronic care continuum related to variables involved with teaching and empowering patients that could be improved to create better transitions. The research has shown that a directed focus results in better patient self-care (Coleman et al, 2006). There is a need for a more integrated role of health care providers in patient centered transitions along the continuum of care as patients move from acute care to their home. There is also a need for a cost-effective intervention that can be applied to multiple populations suffering with heart failure. Decreased cognitive abilities are an underlying issue among chronically ill adults related to both age and disease process that inhibits some of the programs and teaching that is undertaken in hospitals.

Proposed interventions for care transitions have proved effective underscoring the possibilities to improve health outcomes for this population (Voss et al, 2011).

Nursing interventions around the transition of care that increases education and focus on self-care at home can be undertaken to reduce heart failure readmissions. Based on the literature and best practice, discharge calls combined with medication reconciliation will be undertaken to reduce avoidable readmissions, increase knowledge of medications, increase patient satisfaction, and reduce costs.

CHF patients, during an acute inpatient hospitalization event, will be followed utilizing pre-discharge medication reconciliation and self-care education by the CHF navigator. Following discharge, the patients will receive a discharge call based on the standardized tool, providing education along with support to reduce the risk of readmissions due to self-care gaps. Currently these patients are only given physician directed advice about remaining active and following the discharge advice. Current analysis at PLCMMCT suggests there is opportunity to enhance medication reconciliation and discharge education combined with in home follow-up. The continued education after discharge, combined with risk mitigation during the follow-up, will increase the potential for a proper transition from hospital care to self-care and wellness maintenance.

Post-discharge telephone calls will be used to collect data on patient level of understanding of discharge instructions. These calls have proven to be beneficial for patient satisfaction scores as well as in decreasing readmissions. Data collected reveals that patients tend to not retain the discharge instructions at the time of discharge (Willard,

2005). A phone call by a nurse navigator and pharmacist will be made post discharge to ensure the patient understood their discharge instructions and their medication regimen.

The focus on maintaining quality of life, while slowing the progression of the disease, can be achieved through medication management, dietary and lifestyle changes, and patient self-monitoring. Bohachick et al (2012) explains that adherence to medication and lifestyle changes are critical keys to successfully managing CHF thereby reducing hospital admissions, and increasing survival rates. Fernandez, Rajaratnam, Evans, and Speizer (2012) point out the setting of goals in cardiac rehabilitation lead to improvements in health based on patient's behaviors.

Readmissions are increased when patients do not receive proper education and are not prepared for the transition from the acute care setting home. In order to validate interventions that are carried out, evaluation of outcomes is required (Willard, 2005). Evaluating outcomes determines if a particular intervention was worth doing. Measuring patient outcomes helps make decisions about managing their care (Willard, 2005). Understanding how well the intervention improved the patient's outcome toward better health will help determine continued use.

The patients who received the enhanced education, medication reconciliation, and post discharge follow up are expected to show a difference in functional capacity with regard to activities of daily living and no readmissions within the 30 days. In creating a positive transition from acute care that leads to reduction in acute care episodes, the CHF Navigator must focus on teaching patients to enhance self-care techniques (Coleman et all, 2004). The CHF Navigator is in the ideal role to provide the type of coaching and

ongoing support in the weeks following discharge. Naylor's intervention, like Coleman's also focuses on empowering the patient, however, Naylor (2004) showed that changes in the plan of care could be expedited to meet the needs of the patients filling the role of both provider and coach.

Epidemiologic research is conducted around how different actions affect behavior change combined with how these changes can influence population wellness. Primary and secondary research can be accomplished through a scientific framework that creates a structure to complete the research project. Population health can be improved by establishing evidence-based solutions that will allow us to improve the effectiveness of care delivery. Nash, Reifsnyder, Fabius and Pracilio (2011) explain that if the entire community is engaged in a consistent process using data issue ownership, champions of change, and convergence of constituencies can be garnered.

Enabling patients to better care for themselves with the use of additional education and tools provided can improve quality of life in CHF patients. When done on a global scale, better self-care may reduce the financial hardship on healthcare. Institutions that have best practice can also share these practices through programs such as Hospital to Home (H2H) that help to increase knowledge of these practices (American College of Cardiology, 2012).

Project Evaluation

The DNP-prepared nurse should be able to effectively use evaluation methods to analyze data from evidence-based interventions in order to determine the best methods for positive outcomes. Regardless of the research design or model chosen, planning

around evaluation begins at the onset of an intervention with the end or hypothesis in mind. Using epidemiologic studies, results can be analyzed through the evaluation process to demonstrate how screening or intervention can potentially improve population health. AACN requires the doctoral prepared nurse be able to predict and analyze in order to design evidence-based interventions to improve health (American Association of Colleges of Nursing, 2006).

Outcomes for the project will be determined by broadly defined goals and narrowly defined and measurable objectives. The broad goal of this project is to validate an education tool that can be used post discharge to reduce preventable hospital readmissions by providing CHF patients at PLCMMCT a safe and effective transition from hospital to home.

The specific and measureable objectives, outcome indicators, and outcome expectations of the program:

Objective: Implement the risk Stratification tool for the CHF patient that can reduce the number of readmissions in a 30-day period among CHF patients discharged home from PLCMMCT following an emergency department (ED) visit or inpatient stay for CHF related illness who received the nurse led follow-up.

- Outcome Measure 1: Successful use of the tool in identifying patients at high risk for readmission through validation by the CHF navigator.
- Outcome Expectation 1: List of identified high risk for readmission CHF patients for CHF Nurse Navigator to implement specific interventions.

- Outcome Measure 2: Readmission rate of those identified by the tool as high risk using interventions as outlined.
- Outcome Expectation 2: No 30-day readmissions within the group of CHF patients receiving the interventions will be less than a group of the same number who did not receive the interventions.

Friis & Sellers (2009) explain that the benefits or results of an intervention that is planned should not be assumed, but should be quantified. In this way, EBP can be used to help an investigator make assumptions based on previous work that may resemble or share characteristics of a program being planned. A community study results in a group that either receives the new intervention or not, and both groups are evaluated for the outcomes.

The advancements in medicine and an increasing proportion of lifestyle diseases have created a need for patients to manage their disease (Otsu & Moriyama, 2011). Patient's lives are greatly altered by onset and potential deterioration of chronic disease. With this in mind, the formative and process evaluations were assessed as an education transition of care approach for patients with heart failure to maintain quality of life and reduce readmissions to the hospital was considered. CHF is responsible for high rates of hospitalization and is a significant source of morbidity and mortality especially when in combination with multiple diseases.

The final stages of evaluation that should be considered are the impact and outcome evaluations. Both of these stages inform program planners on progress towards

the goals. The surveys collected and analyzed as completed by the CHF experts will be used as a primary measure of success of a validated implementable tool.

Coleman et al (2006) demonstrated that recognizing the key roles patients play in their own care enabling active participation lowers readmission rates. When hospitals are surveyed, medication reconciliation is acknowledged as not being standardized (Walker, 2012). Walker further acknowledges the collaboration efforts with nursing and pharmacy in improving medication accuracy upon discharge can facilitate better transitions in care.

Fundamentally, the admission and discharge to the hospital alone place a patient at great risk due to inadvertent information loss or communication gaps (Kwan, Lo, Sampson & Shojania, 2013). When 67% of patients admitted to hospitals have medication errors (Kwan et al, 2013) we have that the opportunity to make small changes that can significantly improve outcomes (Walker, 2012).

There are many factors that may create issues in studies and quality improvement efforts that must be taken into consideration in the planning phases. In the case of this CHF intervention, the size of the group, along with non-compliance, could limit generalizability. Larger studies can be more accurate and reduce measurement error, but can be costly and take a greater period of time to complete. In the case of CHF education, and a program around transitions of care, noncompliance is a known issue.

In this, and other evaluations of a program, focus needs to be targeted where on specific issues and developed so expense can be minimized to sustain actions. An effective program is accessible to all and addresses lifestyle and dietary changes, exercise, and medication management. The quality of life for patients, families, and the

community at large should be improved. The risk stratification tool can be a foundational step in reducing avoidable readmissions.

Summary

The future of health care is dependent on a need for increased emphasis on inter-professional collaboration by health care providers (Park, Hawkins, Hawkins & Hamlin, 2013). The medication reconciliation process can be enhanced by the interaction between nursing and pharmacy. Specifically, Park et al., (2013) explains that inter-professional collaboration for older adults with chronic conditions can result in comprehensive follow-up care leading to reduced morbidity, and reduced health care costs.

The DNP uses research findings to improve patient care by bridging the gap between research and practice through a model of Translation Research. Translational Research is an emerging model (Studt, 2014) allowing the DNP to translate the research into clinical practice. If health in a community or within a population is to be positively affected, the culture along with the environment must be addressed. Psychosocial epidemiology is described by Friis & Sellers (2009) as a broad concept that includes psychological, behavioral and social factors. Psychosocial factors play an important role in individual health while having a significant impact on population health. Change in behavior is important when considering the relationship between psychosocial risk factors and health outcomes.

Patients must manage their daily life and be equipped to self manage chronic disease. Otsu & Moriyama (2011) point out that advancements in medicine and an

increasing proportion of lifestyle diseases are creating the need for patients to manage their disease.

This proposal outlines the implementation of a risk stratification tool, as well as standardized interventions to be implemented upon identification of high-risk patients based on the evidence outlined. The plan is structured to use the risk stratification tool to identify patients who have an increased risk for readmission based on scores obtained from the tool. The intervention of the post-discharge follow-up call by a pharmacist and CHF nurse navigator will be implemented. An assessment to determine the compliance of patients with their medication regimen as well as the readmission rate will be performed. Analysis will review the efficacy of the interventions and determine if the outcomes are sufficient to continue with the program as designed, or make further adjustments to the identified interventions.

Implementation of a standardized risk stratification tool that identifies patients at risk for re-admission can ensure that standardized interventions and follow-up are implemented. This standardization will improve the quality of life for patients with CHF as well as decrease the financial penalties assessed on an institution that is unable to successfully transition these patients. Including a pharmacist and a nurse navigator that follow standardized work will ensure consistency in the practice and evaluation of the interventions.

Chapter 4: Discussion and Implications

Evaluation of Findings

The Care Transition Gaps: Risk Identification and Intervention project has been approved by Walden University Institutional Review Board (IRB) reference number 01-08-15-0124066 and has been overseen by Providence Little Company of Mary Medical Center Torrance IRB.

The project design has moved from premise to proposal as a grand design, into a final manageable cost effective approach to work on the issues around CHF re-admissions. The project has been downsized, leaving more aspects to pursue in the future. Expansion on studies or work that has already been done could add to the body of work that can lead to outcome improvements. The evaluation and outcomes of this small project show readmissions can be reduced with a large-scale population intervention could achieve.

The results and findings of this prospective quality intervention have shown positive outcomes on multiple levels. The Risk Stratification tool did work as it was intended in identifying patients at high risk for re-admission related to CHF. The tool also helped the Nurse Navigator ensure that needed nursing interventions were undertaken. The outcome expectation of a list of identified high risk for readmission CHF patients for CHF Nurse Navigator to implement specific interventions was achieved. The CHF Nurse Navigator did risk score and work with all twenty-five patients.

The second outcome expectation was that the number of 30-day readmissions within the group of CHF patients receiving the interventions would be less than a group of the same number who did not receive the interventions was achieved. Twenty-five patients were screened and monitored for re-admission. One of the patients was readmitted, but this was unrelated to CHF diagnosis, twenty-four of the patients did not experience readmission within 30 days of discharge.

Discussion of Findings

One of the fundamental findings in this project was the dynamic of the collaborative team; working together to ensure patients receive the elements of care necessary to transition them home maintain health improvement. Orienting the collaborative team to the process and Risk Stratification Tool was key to the success in carrying out crucial interventions designed to fill the gaps that many CHF patients experience during transitions of care. Medication management, dietary and lifestyle changes, and patient self-management are a few things that were found to help fill these gaps as patients transition home.

The initial identification of CHF patients admitted proved to be difficult until a report was created that helped filter the patients based on diagnosis. Once the patients were identified the implementation of the Risk Stratification Tool went very well with CHF Nurse Navigator handling all patients.

Implications

Re-admissions of patients are occurring through a variety of causes (Kelly, M., 2011). Re-admissions are increased when patients do not receive proper education and

are not prepared for the transition from the acute care setting home. Physical activity changes post discharge, improve health function and improve quality of life. The patients who received the enhanced education, medication reconciliation and post discharge follow up are expected to show a difference in functional capacity with regard to activities of daily living and no readmissions within the 30 days. In creating a positive transition from acute care that leads to reduction in acute care episodes the APN must focus on teaching patients to enhance self-care techniques (Coleman et all, 2004).

The future of health care is inter-twined with a need for increased emphasis on inter-professional collaboration by health care providers (Park, Hawkins, Hawkins & Hamlin, 2013). The medication reconciliation process can be enhanced by the interaction between nursing and pharmacy. Specifically, Park (2013) explains that inter-professional collaboration for older adults with chronic conditions can result in comprehensive follow-up care leading to reduced morbidity, and reduced health care costs.

The project proved important to practice at PLCMMCT, as the tool served to highlight problems with care being provided. This creates opportunities for the team to work on identified problems and pilot changes in process that can improve patient outcomes. The tool served as a patient centered audit that enables the team to move resources to the greatest areas of weakness. The role of the CHF Nurse Navigator highlighted the need for individual patient case management in cases of complex multi-disease processes. The project shows promise for population intervention to reduce CHF readmissions, improving the quality of care provided in transitions. In the case of PLCMMCT specifically the project has offered insight into how care can be both

standardized to reduce variation in services provided and tailored for individual patient needs.

Project Strengths and Limitations

One of the strengths of the project has been the collaboration of multiple disciplines in carrying out the interventions based on the Risk Stratification Tool. The risk tool proved beneficial in not only identifying the CHF patients that were high risk, but also determining which interventions should be used. Additionally the follow up interventions that are built into the tool created a standard to follow the patients post discharge creating connections from the care received in the hospital to the care needed post discharge.

Another benefit of the tool was it helped pinpoint strengths and weaknesses with the care needed while the patients were in the hospital. Weakness in the hospital can lead to further gaps as patient's transition to other care settings. The pharmacist involvement in these patients care proved to be very strong as all patients were followed by a pharmacist and received identified interventions. Case Management and Home Health Care involvement did not take place where their interventions, based on the tool, would have been beneficial. However based on the project design the Nurse Navigator was serving in the capacity of a CHF Case Manager.

The project was designed around the CHF Nurse Navigator coordinating the interventions which was a strength but also felt to be a limitation. Certainly having one person following the twenty-five patients in the project proved beneficial. However it is likely not a sustainable direction with penalties around re-admission on CHF and other

diagnosis being added for readmission penalties. Based on this, the strength of the tool and standardization of interventions proven to help lower CHF re-admissions the primary nurses role should be further explored for participation in hospital preparation for transitions home.

One challenge identified was the follow up appointments with the primary care physician after discharge. Overall appointments with a primary physician were a challenge even for the health team professionals to arrange. There is an opportunity to explore a nurse driven outpatient follow up clinic for timely follow-up and facilitating physician involvement post discharge.

The Risk Stratification Tool can be made clearer with greater clarification of who is going to carry out the interventions or ensure that they are carried out. Based on the interventions carried out on the patients it appears that the health team would have benefited from check system based on the individual work that needed to be carried out. Recommendations for remediation of limitations would begin with adjusting the Risk Stratification Tool to be color-coded and made clearer to ensure the multidisciplinary team can carry out interventions timely.

Analysis of Self

I am currently working in Nurse Administration for Providence in California as the Chief Nursing Officer. My focus has been on leadership as this has where I have spent a great deal of my career as well as in as a specialty. My main goal in obtaining my DNP has been to advance my education in a way that would enable me to bring improvements in nursing practice to the bedside. I have gained a great deal of respect for

my fellow classmates/colleagues and the varied degree of expertise. I am grateful for their examples along with the many experiences shared throughout all my courses.

I have completed my practicum hours in Nurse Administration alongside a Chief Operating Officer who is a RN with a remarkable level of human caring an example of how a professional nurse can care for a community. When considering patient centered approaches to care, this mentor has served as a wonderful example of keeping the focus on the patient. My hours have been very exciting as we experience the many changes occurring in health care.

Leadership

Moving projects involving evidence-based practice can be very challenging with the varying disciplines and personalities involved. In my experience in this practicum and from experience in the profession, perceptions and communication are key factors in either moving EBP or solving patient care issues. When considering leadership, relationships play a vital role in creating alignment or personal investment. Manion (2005) discusses relationships as one of four key domains of the competencies needed by leaders.

In reflecting on the courses and my practicum setting, I have been in leadership positions that have enabled me to tap into the resources and expertise quickly. An example was when we were interviewing CNOs, CFOs and others on the executive team. I was already very familiar and met often with these leaders. These relationships made accomplishing some of the tasks at hand much easier.

It is a challenging time for leadership in nursing as health care is rapidly changing. I had stated following nursing school that I would never lead nurses. Quite the opposite has been true. As a leader and now in establishing relationships for my practicums, social competencies have played an important role in my success. The leader must be emotionally intelligent at not only the individual level but social as well. Social awareness as Manion (2005) describes it, in recognition and social competence. If there is no relationship the leaders ability to affect change is greatly deteriorated from the onset. I have been able to form good relationships with many at my practicum site; this has helped with the process of change. In fact in most cases it would be difficult if not impossible to get any idea off the ground without foundational relationships.

My experience around this project with respect to changing practice based on evidence will get better from exercising the skills. This will come from leveraging servant leadership and using EBP change to improve patient care. However being honest about where I am at in the growth process and inviting others to join the journey will continue to be helpful.

Advanced Nursing Practice

The strength of the APN in caring for elderly patients suffering from CHF can be found in their attention to all of the physical, psychosocial, and financial problems these frail patients face (McCauley, Bixby & Naylor 2006). The DNP Essentials (AACN, 2006) address the specific core competencies necessary for advance practice in nursing. The practicuum experience and project oultined here have specifically addressed the following DNP essentials:

- Essential I: Scientific Underpinnings for Practice
- Essential VI: Inter-professional Collaboration for Improving Patient and Population Health Outcomes
- Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health (AACN, 2006)

The AACN Essentials of practice competencies help to articulate the level of practice that the DNP specialty nurse must practice. The work on the project has offered some great opportunities to open the eyes of others through my research and examining the literature. Just as my perception has changed during the process of the practicum and course work, so can the perception of my fellow nurses through involvement in EBP. Walsh (2010) explains EBP as a process that enables holistic and individualized care to be developed in a way that uses best practice in caring for patients. Educating and leading from this level of nursing will ensue the next generation of nurses is prepared to provide safe and effective patient centered care.

Improving Health Outcomes

The continuum of care is fragmented with opportunities to make improvements in transitions home through behavioral modifications (Kay et al, 2006). There are not only gaps in the transitions occurring in health care but also in the knowledge of caregivers in understanding these gaps. Creating tools that place emphasis on patient centered care will help population heath and enable links to services that currently do not exist. There is a great deal of potential to advance and improve care.

Informing Health Care Policy

Hospitals are making needed adjustments in reducing readmissions based for the most part on penalties being imposed by CMS. The steps being taken are long overdue, but should still be based on the patients rather then penalties that will be incurred. Patients continue to be treated more quickly reducing LOS only inviting re-admissions to occur. While the system is being revamped other aspects of the health care curve have not caught up. Pushing patients to be treated quicker requires healthcare be operationally prepared as systems that link the continuum of care. This project has highlighted opportunities to improve healthcare policy around home health benefits. Lower length of stays can be maintained if post acute services are reimbursed and aimed at linking future care to interventions provided in acute care settings. The project has shown the benefit of home health care is not always available when warranted.

Summary

Hospitals know that in order to provide services in today's health care we need to be flexible and adaptable to accommodate changes while ensuring that the care nurses provide is of the quality expected by those using the services (Walsh, 2010). In thinking about the health-promotion and disease-prevention around CHF, there are many initiatives related to this disease, as it is an international health issue. The APN is in the ideal role to provide the type of coaching and ongoing support in the weeks following discharge.

Any goal that helps patients and families improve their quality of life, understanding of the disease and potentially reduces health care costs is a step in the right

direction. My fundamental understanding of EBP has evolved from these courses. While it has been stated that a DNP-prepared nurse has ethical and professional obligations related to disseminating findings I would challenge that all registered nurses should take up this responsibility. I am impressed with the literature that is making this easier for all nurses such as the work by Rossworm and Larrabee Model (1999).

My perception readmission related to CHF has changed in that it is much more complicated than previously imagined or studied. This has narrowed my attention and helped me begin to hone in on aspects that I can effect change. In the short term, there are costs related to improving transitions of care. Even in its simplest form, for example, telemedicine for this population has monthly fees associated with the technology. However, the long-term results show promise in improving quality of life and health for this population at lower costs.

Section 5: Scholarly Product

Dissemination is an important aspect of the DNP role both in educating and pursuing EBP. My scholarly project will be a poster presentation presented at the facility once the project is complete. The goal is to use the standard work created for the CHF population and move it to additional populations at risk for readmission. The long term results of the project will be tracked for inclusion for magnet designation and possible presentation at future professional nursing conferences. The journal of case management is one professional journal that could be used to further present an investigation on readmissions reduction and transition of care improvements.

Most importantly, nursing is evolving, helping registered nurses use evidence based practice to bring the practice of nursing along ensuring patients remain the center of their care is of the utmost importance.

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Appendix A

Risk for Readmission Assessment and Intervention Checklist

Patient Label Here

Risk for Readmission ☐*High Risk for readmission contact Case manager = 5 points or more. (Consider readmit, ☐ Date assessed: _____ Not at risk for Readmission at this time. Risk assessment score_____

Score **Possible/earned**	**Risk**	Need / Complet	**Risk Specific Interventions**
5 point	**Readmit last 30 days**	☐☐	Contact Case management
1 point/	**Problem medications** (A1-C > 8.5%, anti-coagulation, high dose narcotics)	☐☐ ☐☐ ☐☐ ☐☐	Pharmacy consult RN complete Diabetes Survival Skills with teach back Pain consult MD increase home diabetes medication to lower A1c
1 point/	**Psychiatric complications** (acute psychiatric issues, history of mental health disorder or untreated mental health disorder that hinders self-care abilities.	☐☐ ☐☐ ☐☐ ☐☐	Indicate need for psychiatric medication order Psychiatric consult Indicate need for psychiatric follow-up Social worker consult
1 point or 5 pts. automatic	**Principal diagnosis** (Stroke, DM, CAP PNA, Cancer, COPD)	☐☐ ☐☐ ☐ ☐☐	Stroke education with teach back RN complete Diabetes Survival Skills with teach back

high risk for CHF/	Acute Heart failure ACUTE is score of 5.	HF education with teach back ☐☐ MD review core measure checklist
1 point/	**Polypharmacy** (>8 routine medications)	☐☐ Pharmacy consult ☐☐ MD collaborate with pharmacist regarding ongoing prescriptions
1 point/	**Poor health literacy** (literacy screening tool) How often do you need to have someone help you when you read instructions, pamphlets or other written material from your doctor or pharmacy?	☐☐ Home health consult ☐☐ ☐☐ Identify key learner Ensure teach back with education
2 points/	**Patient support** (absence of caregiver to assist with discharge and home care)	☐☐ SW consult explore options to increased pt support
2 points/	**Prior hospitalization** (non-elective in the last 60 days.	☐☐ Review reasons for rehospitalization in the context of prior hospitalization in interdisciplinary rounds
1 point/	**Palliative care Need**	☐☐ Palliative care consult
	Total score	

***High Risk for Readmission Universal Interventions**	**Comment:** *Must complete below interventions by Discharge
☐ PCP verification ☐ Established ☐ New ☐ Vasek Polak	☐ Discharge AVS highlight reason pt in hospital, MD appt, HHC, DME, Meds reviewed and reason taking meds. ie BP, Water pill, heart rhythm, etc.
☐ Follow-up appointment 5 days post discharge	☐ Outpatient Diabetes Program Referral faxed 310-543-7283

scheduled date time and location_____ ☐ Home health order. ☐ Medication filled Prior to discharge	CM/Nurse schedule at 310-543-7281 _____ ☐ (Self-Pay) Vasek Polak Diabetes Goal Program – CM Fax will facesheet ☐ Vasek Polak Medical Home information provided ☐ Med reconciliation complete by pharmacy ☐ CHF Support Group and Navigator information

Admission Nurse: _____ (Print) Discharge Nurse:_____

This form is not a permanent part of the medical record. Form is kept case managers box when complete and on D/C.